Mail your completed ITP, applicable State License or tax status verification, completed W-9, signed EE and CAA agreement(s) to:

Healthy Families & Pre-Existing Condition Insurance Plan
EE/CAA Registration
625 Coolidge Drive Suite 100, Folsom, California 95630
Attention: EE/CAA Liaison Department
Email: ee-caaLiaison@maximus.com
Fax: (916) 673-4500 **Phone**: (800) 279-5012

1. Indicate the type of Enrollment Entity your organization is registering as:
   _____ NEW Enrollment Entity (EE) Healthy Families
   _____ NEW Enrollment Entity (EE) Pre-Existing Condition Insurance Plan
   _____ RENEWING Enrollment Entity (EE) if your payment contract has expired

2. If you checked "**RENEWING Enrollment Entity**," please write your previous EE number here: _____

3. Organization Name _____

Identify the person who is authorized to enter into this agreement. This must be the same person who signs the EE Agreement/W-9 Tax Form.

4. Authorized Person_____Title_____

5. Telephone Number (_____)_____

6. E-mail address _____

Identify the person who is the authorized contact for billing inquiries.

7. Authorized Billing Name _____ Title _____

8. Billing Telephone Number (_____)_____

All payment checks and statements will be mailed to the billing address. (Billing addresses are verified with a W-9 Tax Form.)

9. Business Billing Address_____

City _____ State _____ Zip _____

Identify the person who will be the contact for applicants seeking application assistance.

Important - This contact information will be published on HFP and PCIP websites.
If you don't want your contact information published on HFP and/or PCIP websites, check the appropriate box(es).
HFP☐ PCIP☐

10. Outreach Contact Name _____Title _____

11. E-Mail Address _____

12. Telephone Number (_____)_____ Fax Number (_____)_____

13. Service Location Address_____

City _____ State _____ Zip _____

County _____

If you prefer general letters to be mailed to an address other than the service location address on line 13, include a mailing address.

14. Business Mailing Address_____

City _____ State _____ Zip _____

PLEASE IDENTIFY A PRIMARY CATEGORY FOR YOUR ORGANIZATION. (Check only one.) You must provide a copy of your State license or proof of tax-exempt status.

15. **Category** — **Required Document**

_____ **SCH** – School — Tax ID on District Letterhead
_____ **PRO** – Provider — State License
_____ **HOS** – Hospital — State License
_____ **FBO** – Faith-Based Organization — Proof of 501(C)3 from IRS
_____ **INS** – Insurance Broker or Agent — State Insurance License
_____ **TAX** – Tax Preparer — State Tax Certificate
_____ **CLI** – Clinic — State License or Certificate
_____ **PLN –** Health, Dental or Vision Plan — Confirmation from MRMIB – Approved Application Assistance Plan

_____ **GOV** – Government
(*Please initial below next to the sub-category that applies to your organization):*
_____ County Department of Public Health (except those which provide health, dental or vision care to children). — Tax ID on County Letterhead
_____ City Health Department — Tax ID on City Letterhead
_____ City Government Agency — Tax ID on City Letterhead

_____ **CBP** – Community-Based Program
(*Please initial below next to the sub-category that applies to your organization):*
_____ Licensed Day Care Provider — State License
_____ A Direct State Maternal and Child Health Contractor — State License
_____ WIC Supplemental Food and Nutrition for Women, Infants and Children — State License
_____ Parent Teachers Organization — Proof of 501(C)3 from IRS or Tax ID on Company Letterhead
_____ Indian Health Services Facility — State License or a Licensure exemption letter from the California Department of Public Health

_____ An organization meeting ALL of the following criteria: — Proof of 501(C)3 from IRS
1. Significant interaction with children or parents of children who represent the target market for the two programs;
2. The organization is not a licensed health, dental or vision plan, or an organization providing health, dental or vision care to children;
3. The organization has a federal Tax ID# and is a bona fide non-profit entity as determined by the Internal Revenue Service.

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16. *YOUR ORGANIZATION WILL PROVIDE ASSISTANCE IN THE FOLLOWING LANGUAGES:*

_____ Armenian	_____ Farsi	_____ Russian
_____ Cambodian	_____ Hmong	_____ Spanish
_____ Chinese (Cantonese)	_____ Korean	_____ Vietnamese
_____ English	_____ Laotian	_____ Other_____

17. Your organization will accept referrals during the hours of: (Check all that apply)

☐ 8:00 a.m. – 5:00 p.m. M-F ☐ After 5:00 p.m. M-F ☐ Other Hours: _____

☐ Saturday Hours: _____ ☐ Sunday Hours: _____ ☐ Available By Appointment

Certified Application Assistance (CAA) Staff

18. List all of your staff who have completed certification training and possess CAA, HFP and/or PCIP certification. If necessary, attach another sheet of paper. The ITP must include a signed "Certified Application Assistant Agreement" for each of the persons identified and a copy of the signed Agreement must be given to each person.

CAA Staff	CAA Number (9 digits)	CAA E-Mail Address

19. List all of your new staff that need HFP and/or PCIP certification training. The ITP must include a signed "Certified Application Assistant Agreement" for each of the persons identified and a copy of the signed Agreement must be given to each person. If necessary, attach another sheet of paper.

Program Training Needed	New Application Assistance Staff	E-Mail Address
HFP ☐ PCIP ☐		
HFP ☐ PCIP ☐		
HFP ☐ PCIP ☐		
HFP ☐ PCIP ☐		
HFP ☐ PCIP ☐		
HFP ☐ PCIP ☐		

20. **HFP CERTIFICATION TRAINING INFORMATION**

Certification training provides a comprehensive overview of the Healthy Families application and eligibility determination. The Healthy Families Program offers a web-based training and certification course to NEW Certified Application Assistants. A Reference Manual and other useful training materials are available at www.healthyfamilies.ca.gov, as resource tools for application assistance. It may be helpful for staff to review the HFP website for current program information. All candidates for training must complete a CAA agreement prior to training. At the end of the 5-hour web-based training course, a certification exam will be given and successful candidates will receive a certificate and will become Certified Application Assistants (CAAs). CAAs have the authority to provide assistance to families.

21. **PCIP CERTIFICATION TRAINING INFORMATION**

Certification training provides a comprehensive overview of the Pre-Existing Condition Insurance Plan application and eligibility determination. Pre-Existing Condition Insurance Plan offers a web-based training and certification course to NEW Certified Application Assistants. It may be helpful for staff to review the PCIP website at www.pcip.ca.gov for current program information. All candidates for training must complete a CAA agreement prior to training. At the end of the 2-hour web-based training presentation, a certification exam will be given and successful candidates will receive a certificate and a PCIP CAA number by mail. CAAs have the authority to provide PCIP assistance to families and request a payment.

22. **ENTITY AGREEMENT**

This document serves as an Agreement between the State of California and the Enrollment Entity (EE) for the Healthy Families Program (HFP) and the Pre-Existing Condition Insurance Plan (PCIP):

- The State of California agrees to provide enrollment materials and to assign a numerical Certified Application Assistant (CAA) number to each qualified enrollment participant upon successful completion of the certification training and execution of the "Certified Application Assistance Agreement".
- Participating organizations agree to provide all staff and facility resources to perform outreach to the target population. EE agrees to ensure the confidentiality of all applications, records and information received in written, graphic, oral or other tangible forms and to perform enrollment assistance by a CAA. EE agrees to provide a copy of the "Certified Application Assistant and Agreement" form to each CAA.
- The EE and CAA must:
  - Never accept money or premium payments from applicants,
  - Never mail the application for the applicant,
  - Never coach on what information to include on the application regarding income, residency, alienage and other eligibility rules,
  - Act in a professional and courteous manner.
  - Wear a badge that identifies the person's name and CAA number, as well as the EE name and number. The badge can NOT identify the CAA as an employee of the State of California or of the Healthy Families Program, or of the Pre-Existing Condition Insurance Plan.
  - Never divulge to any unauthorized person, any information obtained while assisting individuals with their applications, or information obtained in conjunction with a referral,
  - Never coach or recommend one plan/provider over another,
  - Never invite or influence an employee or their dependents to separate from employer-based group health coverage, or arrange for this to occur,
  - Comply with Managed Risk Medical Insurance Board and Department of Health Services fraud prevention policies and safeguards against fraudulent actions,
  - Ensure that the EE and CAA section of the application is complete: family signature and date, CAA signature and date, EE number (5 digits) and CAA number (9 digits). The section MUST be completed correctly, using an ink pen or typewriter, and contain original signatures.
- No provision of this Agreement shall be considered waived, amended, or modified by either party without prior written and signed authorization from State of California.
- No license, expressed or implied, under any copyright is granted hereunder to the EE.
- EE and the officers, agents and employees of the EE shall act in an independent capacity and not as officers or employees or agents of the State of California in the performance of this Agreement.

23. **TERMINATION AND CANCELLATION**

The Department of Health Services, the Managed Risk Medical Insurance Board and the Program partners are not liable to any person for any harm resulting from the organization's actions. The State of California may terminate the organization's participation in the program without cause immediately by a written notice thereof. In addition, the Managed Risk Medical Insurance Board may terminate the organization's participation pursuant to its regulations. You acknowledge that you are a business partner to the HFP and PCIP and that neither you nor the CAAs have any entitlement to continue providing enrollment services for compensation. This Agreement and all documents attached to or reference herein, including the Application and Certification Training, Reference Manual, the Healthy Families Program Handbook and the Pre-Existing Condition Insurance Plan Handbook and the EE's Registration of the Invitation to Participate, constitute the entire Agreement between the EE and the State of California. This Agreement will continue until terminated by the State of California.

24. **RELEASE AND WAIVER OF LIABILITY**

The Healthy Families and Pre-Existing Condition Insurance Plan Application Assistance Program will be comprised of enrollment entities (EE) that will be assisting families in filling out the HFP and PCIP application. This waiver pertains to the EE as undersigned, his/her personal representatives and Certified Application Assistants. EE is not affiliated with the State of California. EE agrees to obey all city, county, state and federal laws and assumes full responsibility for any risk, injury, death or property damage related to the HFP or PCIP application assistance whether caused by EE's negligence or otherwise. EE hereby releases, waives, discharges and covenants not to sue The State of California, its originators, participants, members, volunteers, consultants, contractors and sub-contractors for liability, loss, injury, death or property damage arising out of or related to the EE's participation in the HFP or PCIP application assistance, whether caused by EE's negligence or otherwise.

MANAGED RISK MEDICAL INSURANCE BOARD

Organization Name

Authorized Name (Please Print)

Authorized Signature / Date

Managed Risk Medical Insurance Board Authorized Signature/ Date

25. CERTIFIED APPLICATION ASSISTANT AGREEMENT

This document serves as an Agreement by, and code of conduct for, the Certified Application Assistant (CAA) for the Healthy Families Program (HFP) and the Pre-Existing Condition Insurance Plan (PCIP). As a condition of being certified as a CAA, the State will provide enrollment materials and assign a numerical Certified Application Assistant (CAA) number only to qualified enrollment participants upon successful completion of the certification training and execution of this Agreement by the participant.

- The CAA must:
  - Never accept money or premium payments from applicants,
  - Never mail the application for the applicant,
  - Never coach or suggest information to include on the application regarding income, residency, alienage and other eligibility rules,
  - Act in a professional and courteous manner,
  - Wear a badge that identifies the person's name and CAA number, as well as the EE name and number. The badge can NOT identify the CAA as an employee of the State of California or of the Healthy Families Program, or of the Pre-Existing Condition Insurance Plan,
  - Ensure the confidentiality of all applications, records and information received in written, graphic, oral or other tangible forms and to perform enrollment assistance,
  - Never divulge to any unauthorized person, any information obtained while assisting individuals with their applications, or information obtained in conjunction with a referral,
  - Never coach or recommend one plan/provider over another,
  - Never invite or influence an employee or their dependents to separate from employer-based group health coverage, or arrange for this to occur,
  - Comply with Managed Risk Medical Insurance Board and Department of Health Services fraud prevention policies and safeguards against fraudulent actions,
  - Ensure that the EE and CAA section of the application is complete: family signature and date, CAA signature and date, EE number (5 digits) and CAA number (9 digits). This section MUST be completed correctly, using an ink pen or typewriter, and contain original signatures.
- No license, expressed or implied, under any copyrights is granted hereunder to CAA.
- CAAs shall act in an independent capacity and not as officers or employees or agents of the State of California in the performance of this Agreement.

26. TERMINATION AND CANCELLATION

The Department of Health Services, the Managed Risk Medical Insurance Board and the Program partners are not liable to any person for any harm resulting from your organization's actions. The State may terminate your participation in the program without cause immediately by a written or oral notice thereof. You acknowledge that the enrolling entity through which you provide application assistance is a business partner to the HFP program and PCIP and that neither neither you nor the EE have any entitlement to continue providing enrollment services or to continue being certified as an EE or CAA. All documents attached to or referenced herein, including the Application and Training Certification Reference Manual the Healthy Families Program and the Pre-Existing Condition Insurance Plan Handbook and the EE's Registration of the Invitation to Participate, are a part of this Agreement by the CAA. This Agreement shall be in effect commencing on the date signed by the CAA and shall continue unless terminated by the State.

27. RELEASE AND WAIVER OF LIABILITY

The Healthy Families and Pre-Existing Condition Insurance Plan Application Assistance Program will be comprised of CAAs that will be assisting families in filling out the HFP and PCIP applications. This waiver pertains to EE representative identified below, his/her personal representatives and Certified Application Assistants. The CAA is not affiliated with the State. CAA agrees to obey all city, county, state and federal laws and assumes full responsibility for any risk, injury, death or property damage related to the HFP or PCIP application assistance whether caused by CAA's negligence or otherwise. CAA hereby releases, waives, discharges and covenants not to sue the State, its originators, participants, members, volunteers, consultants, contractors and sub-contractors for liability, loss, injury, death or property damage arising out of or related to the CAA's participation in the HFP or PCIP application assistance, whether caused by CAA's negligence or otherwise.

28. EE #: ☐☐☐☐☐ CAA #: ☐☐☐☐☐☐☐☐☐

Enrollment Entity Name

CAA Signature

Name of Applicant Assistant (Please Print)

Date

Healthy Families & Pre-Existing Condition Insurance Plan
EE/CAA Registration
EE#_____ **EE Name**_____
625 Coolidge Drive, Suite 100, Folsom, California 95630
Attention: EE/CAA Liaison Department
E-Mail: ee-caaLiaison@maximus.com
Fax: (916) 673-4500 **Phone**: (800) 279-5012

SUB-SITE REGISTRATION FORM

(*Please complete this registration form for **all sites** that will be linked to this EE).*

Sub-Site #1 Identify the primary contact for calls from applicants seeking local assistance.

29. Contact Name _____ Title _____

30. Service Location Address _____

City _____ State _____ Zip _____

E-Mail Address _____

Telephone Number (_____)_____ Fax Number (_____)_____

31. *This site will provide assistance in the following languages:*

_____ Armenian	_____ Farsi	_____ Russian
_____ Cambodian	_____ Hmong	_____ Spanish
_____ Chinese (Cantonese)	_____ Korean	_____ Vietnamese
_____ English	_____ Laotian	_____ Other_____

32. This location will accept referrals during the hours of: (Check all that apply)

☐ 8:00 a.m. – 5:00 p.m. M-F ☐ After 5:00 p.m. M-F ☐ Other Hours: _____

☐ Saturday Hours: _____ ☐ Sunday Hours: _____ ☐ Available By Appointment

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Sub-Site #2 Identify the primary contact for calls from applicants seeking local assistance.

Contact Name _____ Title _____

Service Location Address

_____

City _____ State _____ Zip _____

E-Mail Address _____

Telephone Number (_____)_____ Fax Number (_____)_____

This site will provide assistance in the following languages:

_____ Armenian	_____ Farsi	_____ Russian
_____ Cambodian	_____ Hmong	_____ Spanish
_____ Chinese (Cantonese)	_____ Korean	_____ Vietnamese
_____ English	_____ Laotian	_____ Other_____

This location will accept referrals during the hours of: (Check all that apply)

☐ 8:00 a.m. – 5:00 p.m. M-F ☐ After 5:00 p.m. M-F ☐ Other Hours: _____

☐ Saturday Hours: _____ ☐ Sunday Hours: _____ ☐ Available By Appointment